907 KAR 1:030 & E

Incorporation by Reference

MAP-248, Commonwealth of Kentucky, Cabinet for Health Services, Department for Medicaid Services, December 2001 revision

Home Health Services Manual, June 2006 edition

Technical Criteria for Reviewing Ancillary Services for Adults, February 2000 Edition

Technical Criteria for Reviewing Ancillary Services for Pediatrics, April 2000 Edition

Filed: _____

HOME HEALTH SERVICES MANUAL

Kentucky Medicaid Program
Home Health Benefits
Policies and Procedures

Cabinet for Human Resources
Department for Medicaid Services
275 East Main Street
Frankfort, Kentucky 40621

HOME HEALTH SERVICES
USER'S MANUAL
UPDATE LOG

The purpose of this log is to provide a record of changes, additions, and deletions in the User's Manual. As sequentially numbered changes are received and posted in the User's Manual, entry of the change number in the log is expected to provide the user with a mechanism for eliminating errors and omissions.

TRANSMITTAL NUMBER	DATE	(Initials)	TRANSMITTAL NUMBER	DATE	(Initials)

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SECTION I - INTRODUCTION

I. INTRODUCTION

This new edition of the Kentucky Medicaid Program Home Health Services Manual has been formulated with the intention of providing you, the provider, with a useful tool for interpreting the procedures and policies of the Kentucky Medicaid Program. It has been designed to facilitate the processing of your claims for services provided to qualified recipients of Medicaid.

This manual is intended to provide basic information concerning coverage, billing, and policy. It will assist you in understanding what procedures are reimbursable, and will also enable you to have your claims processed with a minimum of time involved in processing rejections and making inquiries. It has been arranged in a loose-leaf format, with a decimal page numbering system which will allow policy and procedural changes to be transmitted to you in a form which may be immediately incorporated into the manual (i.e., page 7.6 might be replaced by new pages 7.6 and 7.7).

Precise adherence to policy is imperative. In order that your claims may be processed quickly and efficiently, it is extremely important that you follow the policies as described in this manual. Any questions concerning general agency policy should be directed to the Office of the Commissioner, Department for Medicaid Services, Cabinet for Human Resources, 275 E. Main Street, Frankfort, Kentucky 40621, or Phone (502) 564-4321. Questions concerning the application or interpretation of agency policy with regard to individual services should be directed to the Division of Program Services, Department for Medicaid Services, Cabinet for Human Resources, 275 E. Main Street, Frankfort, Kentucky 40621, or Phone (502) 564-6890. Questions concerning billing procedures or the specific status of claims should be directed to EDS, P.O. Box 2009, Frankfort, KY 40602, or Phone (800) 756-7557 (In-State) or (502) 227-2525.

B. Fiscal Agent

Effective December 1, 1983, Electronic Data Systems (EDS) began providing fiscal agent services for the operation of the Kentucky Medicaid Management Information System (MMIS). EDS receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

II. KENTUCKY MEDICAID PROGRAM

A. General Information

The Kentucky Medicaid Program, is administered by the Cabinet for Human Resources, Department for Medicaid Services. The Medicaid Program, identified as Title XIX of the Social Security Act, was enacted in 1965, and operates according to a State Plan approved by the U.S. Department of Health and Human Services.

Title XIX is a joint Federal and State assistance program which provides payment for certain medical services rendered to Kentucky recipients who lack sufficient income or other resources to meet the cost of such care. The basic objective of the Kentucky Medicaid Program is to aid the medically indigent of Kentucky in obtaining quality medical care.

As a provider of medical services, you must be aware that the Department for Medicaid Services is bound by both Federal and State statutes and regulations governing the administration of the State Plan. The Department shall not reimburse you for any services not covered by the plan. The state cannot be reimbursed by the federal government for monies improperly paid to providers of non-covered unallowable medical services.

The Kentucky Medicaid Program, Title XIX, Medicaid, is not to be confused with Medicare. Medicare is a Federal provision, identified as Title XVIII, basically serving persons 65 years of age and older, and some disabled persons under that age.

The Kentucky Medicaid Program serves eligible recipients of all ages. The coverage, either by Medicare or Medicaid, will be specified in the body of this manual.

B. Administrative Structure

The Department for Medicaid Services, within the Cabinet for Human Resources, bears the responsibility for developing, maintaining, and administering the policies and procedures, scopes of benefits, and basis for reimbursement for the medical care aspects of the Program. The Department for Medicaid Services makes the actual payments to the providers of medical services, who have submitted claims for services within the scope of covered benefits which have been rendered to eligible recipients.

Determination of the eligibility status of individuals and families for Medicaid benefits is a responsibility of the local Department for Social Insurance Offices, located in each county of the state.

C. Advisory Council

The Kentucky Medicaid Program is guided in policy-making decisions by the Advisory Council for Medical Assistance. In accordance with the conditions set forth in KRS 205.540, the Council is composed of eighteen (18) members, including the Secretary of the Cabinet for Human Resources, who serves as an ex officio member. The remaining seventeen (17) members are appointed by the Governor to four-year terms. Ten (10) members represent the various professional groups providing services to Program recipients, and are appointed from a list of three (3) nominees submitted by the applicable professional associations. The other seven (7) members are lay citizens.

In accordance with the statutes, the Advisory Council meets at least every three (3) months and as often as deemed necessary to accomplish their objectives.

In addition to the Advisory Council, the statutes make provision for a five (5) or six (6) member technical advisory committee for certain provider groups and recipients. Membership on the technical advisory committees is decided by the professional organization the technical advisory committee represents. The technical advisory committees provide for a broad professional representation to the Advisory Council.

As necessary, the Advisory Council appoints subcommittees or ad hoc committees responsible for studying specific issues and reporting their findings and recommendations to the Council.

D. Policy

The basic objective of the Kentucky Medicaid Program is to assure the availability and accessibility of quality medical care to eligible Program recipients.

The 1967 amendments to the Social Security Law stipulates that Title XIX Program have secondary liability for medical costs of Program recipients. That is, if the patient has an insurance policy, veteran's coverage, or other third party coverage of medical expenses, that party is primarily liable for the patient's medical expenses. The Medicaid Program has secondary liability. Accordingly, the provider of service shall seek reimbursement from the third party groups for medical services rendered. If you, as the provider, should receive payment from Medicaid before knowing of the third party's liability, a refund of that payment amount shall be made to Medicaid as the amount payable by the Department shall be reduced by the amount of the third party obligation.

In addition to statutory and regulatory provisions, several specific policies have been established through the assistance of professional advisory committees. Principally, some of these policies are as follows:

All participating providers shall agree to provide services in compliance with federal and state statutes regardless of sex, race, creed, religion, national origin, handicap or age.

Each medical professional is given the choice of whether or not to participate in the Kentucky Medicaid Program. From those professionals who have chosen to participate, the recipient may choose the one from whom he wishes to receive his medical care.

When the Department make payment for a covered services and the provider accepts the payment made by the Department in accordance with the Department's fee structure, the amounts paid shall be considered payment in full; and no bill for the same service shall be tendered to the recipient, or payment for the same service accepted from the recipient.

Providers of medical service attest by their signatures (not facsimiles) that the presented claims are valid and in good faith. Fraudulent claims are punishable by fine and/or imprisonment.

All claims and substantiating records are auditable by both the Government of the United States and the Commonwealth of Kentucky.

All claims and payments are subject to rules and regulations issued from time to time by appropriate levels of federal and state legislative, judiciary and administrative branches.

All services to recipients of this Program shall be on a level of care at least equal to that extended private patients, and normally expected of a person serving the public in a professional capacity.

All recipients of this Program are entitled to the same level of confidentiality accorded patients NOT eligible for Medicaid benefits.

Professional services shall be periodically reviewed by peer groups within a given medical speciality.

All services are reviewed for recipients and provider abuse. Willful abuse by the provider may result in his suspension from Program participation. Abuse by the recipient may result in surveillance of the payable services he receives.

No claim shall be paid for services outside the scope of allowable benefits within a particular specialty. Likewise, no claims shall be paid for services that required, but did not have, prior authorization by the Kentucky Medicaid Program.

No claims shall be paid for medically unnecessary items, services, or supplies.

When a recipient makes payment for a covered service, and that payment is accepted by the provider as either partial payment or payment in full for that service, no responsibility for reimbursement shall attach to the Cabinet and no bill for the same service shall be paid by the Cabinet.

E. Public Law 92-603 (As Amended)

Section 1909. (a) Whoever—

(1) knowingly and willfully makes or causes to be made any false statement or representation of a material fact in any application for any benefit or payment under a State plan approved under this title,

(2) at any time knowingly and willfully makes or causes to be made any false statement or representation of a material fact for use in determining rights to such benefit or payment,

(3) having knowledge of the occurrence of any event affecting

(A) his initial or continued right to any such benefit or payment, or

(B) the initial or continued right to any such benefit or payment of any other individual in whose behalf he has applied for or is receiving such benefit or payment, conceals or fails to disclose such event with an intent fraudently to secure such benefit or payment either in a greater amount or quantity than is due or when no such benefit or payment is authorized, or

(4) having made application to receive any such benefit or payment for the use and benefit of another and having received it, knowingly and willfully converts such benefit or payment or any part thereof to a use other than for the use and benefit of such other person.

shall (i) in the case of such a statement, representation, concealment, failure, or conversion by any person in connection with the furnishing (by that person) of items or services for which payment is or may be made under this title, be guilty of a felony and upon conviction thereof fined not more than $25,000 or imprisoned for not more than five years or both, or (ii) in the case of such a statement, representation, concealment, failure, or conversion by any other person, be guilty of a misdemeanor and upon conviction thereof fined not more than $10,000 or imprisoned for not more than one year, or both. In addition, in any case where an individual who is otherwise eligible for assistance under a State plan approved under this title is convicted of an offense under the preceding provisions of this subsection, the State may at its option (notwithstanding any other provision of this title or of such plan) limit, restrict, or suspend the eligibility of that individual for such period (not exceeding one year) as it deems appropriate; but the imposition of a limitation, restriction, or suspension with respect to the eligibility of any individual under this sentence shall not affect the eleigibility of any other person for assistance under the plan, regardless of the relationship between that individual and such other person.

(b)(1) Whoever knowingly and willfully solicits or receives any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind--,

(A) in return for referring an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) in return for purchasing, leasing, ordering, or arranging for or recommending purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof, shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(2) Whoever knowingly and willfully offers or pays any remuneration (including any kickback, bribe, or rebate) directly or indirectly, overtly or covertly, in cash or in kind to any person to induce such person—

(A) to refer an individual to a person for the furnishing or arranging for the furnishing of any item or service for which payment may be made in whole or in part under this title, or

(B) to purchase, lease, order, or arrange for or recommend purchasing, leasing, or ordering any good, facility, service, or item for which payment may be made in whole or in part under this title,

shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(3) Paragraphs (1) and (2) shall not apply to--

(A) a discount or other reduction in price obtained by a provider of services or other entity under this title if the reduction in price is properly disclosed and appropriately reflected in the costs claimed or charges made by the provider or entity under this title; and

(B) any amount paid by an employer to an employee (who has a bona fide employment relationship with such employer) for employment in the provision of covered items or services.

(c) Whoever knowingly and willfully makes or causes to be made, or induces or seeks to induce the making of, any false statement or representation of a material fact with respect to the conditions or operations of any institution or facility in order that such institution or facility may qualify (either upon initial certification or upon recertification) as a hospital, skilled nursing facility, intermediate care facility, or home health agency (as those terms are employed in this title) shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

(d) Whoever knowingly and willfully--

(1) charges, for any service provided to a patient under a State plan approved under this title, money or other consideration at a rate in excess of the rates established by the State, or

(2) charges, solicits, accepts, or receives, in addition to any amount otherwise required to be paid under a State plan approved under this title, any gift, money, donation, or other consideration (other than a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to the patient)--

(A) as a precondition of admitting a patient to a hospital, skilled nursing facility, or intermediate care facility, or

(B) as a requirement for the patient's continued stay in such a facility, when the cost of the services provided therein to the patient is paid for (in whole or in part) under the State plan, shall be guilty of a felony and upon conviction thereof shall be fined not more than $25,000 or imprisoned for not more than five years, or both.

F. Appeal Process for Refund Requests

In the event of a refund request subsequent to a postpayment review by the Surveillance and Utilization Review Branch (SURS), the provider may appeal the Medicaid agency request in writing by providing clarification and documentation that may alter the agency findings.

If there has been no written response within forty-five (45) days of the refund request, assent to the findings shall be assumed. If no arrangements for payment are made, the amount requested shall be deducted from future payments.

Written clarification shall be sent to:

Director, Division of Program Services
Department for Medicaid Services
Cabinet for Human Resources
Third Floor East
275 East Main Street
Frankfort, KY 40621

SECTION III - CONDITIONS OF PARTICIPATION

III. CONDITIONS OF PARTICIPATION

A. Definition of Agency

A home health agency is a public agency or private organization, or a subdivision of such an agency or organization, whose primary purpose is to provide nursing services on an intermittent or part-time basis and other therapeutic services such as: physical therapy, speech pathology, occupational therapy, home health aide services, medical social services, nutritional counseling services, and medical supplies. These services are provided within the scope and limitations set forth by the patient's physician within a plan of treatment.

In order to receive reimbursement from Medicaid for home health services rendered to eligible recipients, the home health agency shall be granted a Certificate of Need, be licensed as a home health agency, and be certified for participation under Title XVIII (Medicare) and Title XIX (Medicaid).

Information and forms necessary to complete an application to participate in Medicaid are:

1. Application for Participation (MAP-343); and
2. Provider Information Sheet (MAP-344)
3. Copy of Medicare certification
4. Electronic Media Billing Agreement, MAP-346 and Provider Agreement Addendum (MAP-380) for electronic billing

The yellow copy of the Application for Participation (MAP-343) shall be returned to the agency along with a cover letter indicating the provider number, and effective date of participation.

Questions regarding enrollment may be addressed to the Provider Enrollment Section, Department for Medicaid Services, 275 East Main Street, Frankfort, Kentucky 40621, telephone: 502-564-3476.

B. Out-of-State Providers

The out-of-state provider, in addition to the participation requirements listed in A., shall specify whether services will be provided inside Kentucky or in their own state. If services are provided in Kentucky, the home health agency shall have a Kentucky Certificate of Need and appropriate license. If the services are to be provided in their own state, the home health agency shall be a Medicare-certified home health agency and have a license to operate in that state.

C. Change of Ownership

The home health agency shall complete new participation agreement forms whenever the agency has had a change of ownership. The information and forms necessary to complete the application to participate in Medicaid are:

1. Application for Participation (MAP-343); and

2. Provider Information Sheet (MAP-344); and

3. Copy of Medicare certification

4. Electronic Media Billing Agreement, (MAP-346) and Provider Agreement Addendum, (MAP-380) for electronic billing.

These forms shall be submitted along with a cover letter stating that this represents a change of ownership, giving the old agency, the name of the new agency and the effective date of the change.

D. Disclosure of Information (42 CFR 405, 420, 413 and 455)

There are some requirements for disclosure of information by institutions and organizations providing services under Medicare and Medicaid (Titles XVIII and XIX of the Social Security Act.) The Federal regulations implement sections 3, 8, 9, and 15 of the Medicare-Medicaid Anti-Fraud and Abuse Amendments of 1977 (Public Law 95-142). The portions applicable to Medicaid are outlined for you. The regulations are significant and we suggest your attention to them.

Of particular impact on Medicaid providers are the following:

1. The Secretary of the Department of Health and Human Services or the State agency may refuse to enter into or renew an agreement with a provider if any of its owners, officers, directors, agents, or managing employees has been convicted of criminal offenses involving any of the programs under Titles XVIII, XIX, or XX.

2. The Secretary or State agency may terminate an agreement with a provider that failed to disclose fully and accurately the identity of any of its owners, officers, directors, agents, or managing employees who have been convicted of a program-related criminal offense at the time the agreement was entered into.

3. The Secretary may have access to Medicaid provider records.

4. Providers are required to disclose certain information about owners, employees, subcontractors, and suppliers.

In addition to these new requirements, the Federal regulations detail revisions to existing sections on bankruptcy or insolvency and provider agreements, and note information which may be requested concerning business transactions.

E. Patient Consent Forms

Please be advised that neither the Office of Inspector General (Licensing and Regulation or Audits) nor Medicaid personnel are required to have completed patient consent forms prior to or upon reviewing or investigating patient records or provider records which relate to the Kentucky Medicaid Program. (See Section III. H. Medical Records of this Manual regarding inspection of records.

F. Termination of Provider Participation

907 KAR 1:220 regulates the terms and conditions of provider participation and procedures for provider appeals. The Cabinet for Human Resources determines the terms and conditions for participation of vendors in the Kentucky Medicaid Program and may suspend, terminate, deny or not renew a vendor's provider agreement for "good cause." "Good cause" is defined as:

1. Misrepresenting or concealing facts in order to receive or to enable others to receive benefits;

2. Furnishing or ordering services under Medicaid that are substantially in excess of the recipient's needs or that fail to meet professionally recognized health care standard;

3. Misrepresenting factors concerning a facility's qualifications as a provider;

4. Failure to comply with the terms and conditions for vendor participation in the program and to effectively render service to recipients; or

5. Submitting false or questionable charges to the agency.

The Kentucky Medicaid Program may terminate the provider agreement immediately for cause, or in accordance with federal regulations, upon written notice served upon the provider by registered or certified mail with return receipt requested. Otherwise, the Kentucky Medicaid Program shall notify a provider in writing at least thirty (30) days prior to the effective date of any decision to terminate, suspend, deny or not renew a provider agreement. The notice will state:

1. The reasons for the decision;

2. The effective date;

3. The extent of its applicability to participation in the Medi caid Program;

4. The earliest date on which the Cabinet will accept a request for reinstatement;

5. The requirements and procedures for reinstatement; and

6. The appeal rights available to the excluded party.

The provider receiving a notice may request an evidentiary hearing. The request shall be in writing and made within five (5) days of receipt of the notice.

The hearing shall be held within thirty (30) days of receipt of the written request, and a decision shall be rendered within thirty (30) days from the date all evidence and testimony is submitted. Technical rules of evidence shall not apply. The hearing shall be held before an impartial decision-maker appointed by the Secretary for Human Resources. When an evidentiary hearing is held, the provider is entitled to the following.

1. Timely written notice as to the basis of the adverse decision and disclosure of the evidence upon which the decision was based;

2. An opportunity to appear in person and introduce evidence to refute the basis of the adverse decision;

3. Counsel representing the provider;

4. An opportunity to be heard in person, to call witnesses, and to introduce documentary and other demonstrative evidence; and

5. An opportunity to cross-examine witnesses.

The written decision of the impartial hearing officer shall state the reasons for the decision and the evidence upon which the determination is based. The decision of the hearing officer is the final decision of the Cabinet for Human Resources.

These procedures apply to any individual provider who has received notice from the Cabinet of termination, suspension, denial or non-renewal of the provider agreement or of suspension from the Kentucky Medicaid Program, except in the case of an adverse action taken under Title XVIII (Medicare), binding upon the Medicaid Program. Adverse action taken against an individual provider under Medicare shall be appealed through Medicare procedures.

G. Withdrawal of Participation

If a provider terminates Medicaid participation, written notice shall be given to the Cabinet for Human Resources, Department for Medicaid Services at least thirty (30) days prior to the effective date of withdrawal. Payment may not be made for services or items provided to recipients on or after the effective date of withdrawal.

H. Medical Records

Medical records shall substantiate the services billed to Medicaid by the home health agency. The medical records shall be accurate and appropriate. All records shall be signed and dated.

Medical records shall be maintained for a minimum of five (5) years and for any additional time as may be necessary in the event of an audit or other dispute. The records and any other information regarding payments claimed shall be maintained in an organized central file and furnished to the Cabinet upon request and made available for inspection and copying by Cabinet personnel.

SECTION III - CONDITIONS OF PARTICIPATION

I. Patient Rights

As required by the Medicare Program: Home Health Agencies: Conditions of Participation (42 CFR part 484) and therefore, also the Medicaid Program, there are certain rights to which home health patients are entitled and home health agencies shall promote and protect the rights of each individual under their care, including each of the following rights:

1. The right to be fully informed in advance about the care and treatment to be furnished by the home health agency, to be fully informed in advance of any changes in the care or treatment to be furnished by the agency that may affect the individual's well-being, and (except with respect to an individual determined to be incompetent) to participate in planning the care and treatment or changes in care or treatment;

2. The right to voice grievances without discrimination or reprisal for voicing grievances with respect to treatment or care that is (or fails to be) furnished;

3. The right to confidentiality of the clinical records;

4. The right to have one's property treated with respect;

5. The right to be fully informed orally and in writing (in advance of coming under the care of the agency) of;

   All items and services furnished by (or under arrangements with) the agency for which payment may be made under Medicare or Medicaid;

   The coverage available for items and services under Medicare, Medicaid, and any other Federal program of which the agency is reasonably aware;

   Any charges for items and services not covered under Medicare or Medicaid and any charges the individual may have to pay regarding items and services furnished by (or under arrangements with) the agency; and

Any changes in the charges or items and services for which the individual may be liable.

6. The right to be fully informed in writing (in advance of coming under the care of the agency) of the individual's rights and obligations under Medicaid.

7. The right to be fully informed of the availability of the State home health agency hotline.

It shall be the responsibility of the Division for Licensing and Regulations, the Kentucky state survey agency, to assure compliance with the Patients Rights requirements and standards for meeting these requirements under the Medicaid Program.

J. Advanced Directives

Section 4751 of OBRA 1990 requires that adults, eighteen (18) years of age or older, receive information concerning their right to make decisions relative to their medical care. This includes 1) the right to accept or refuse medical or surgical treatment, 2) the right to execute a living will, and 3) the right to grant a durable power of attorney for their medical care to another individual.

These requirements were effective December 1, 1991, as follows, regardless of payer source:

* A hospital shall give information at the time of the individual's admission as an inpatient.

* A nursing facility shall give information at the time of the individual's admission as a resident.

* A provider of home health care shall give information to the individual in advance of the individual's coming under the care of the provider.

* A hospice program providers shall give information at the time of initial receipt of hospice care by the individual.

Additionally, providers shall

(a) Maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization about their rights under State law to make decisions concerning medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate advance directives;

(b) Provide written information to all adult individuals on the provider's policies concerning implementation of these rights;

(c) Document in the individual's medical records whether or not the individual has executed an advance directive;

(d) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(e) Ensure compliance with requirements of State Law (whether statutory or recognized by the courts) concerning advance directives; and

(f) Provide (individually or with others) for education for staff and the community on issues concerning advance directives.

State law allows for a health care provider or agent of the provider to object to the implementation of advance directives. For additional information, refer to KRS 311.634 and KRS 311.982 or consult an attorney.

The following materials are included in the appendix of this manual.

1) Description of Kentucky laws regarding the
   a) Living Will Act
   b) Health Care Surrogate Act
   c) Durable Power of Attorney

2) Living Will Declaration

3) Designation of Health Care Surrogate

4) Advance Directive Acknowledgment

5) Protocol

The cost of reproducing these materials in Medicaid-eligible individuals shall be a Medicaid allowable cost for Medicaid-eligible individuals.

While the requirements for this process are listed above, providers may choose to advise those individuals receiving services prior to December 1, 1991, regarding advance directives.

NOTE: Advanced directives apply for all home health recipients, even those who are "supply only" recipients through the Home Health Program.

SECTION IV - PROGRAM COVERAGE

IV. SERVICES COVERED

Home health care is the provision of medical care and supportive services to a sick or disabled person in his place of residence. The home health agency is responsible for delivering this care to an eligible Medicaid recipient. A large part of the medical care involves teaching the patient or family, whenever possible, to be able to provide the care. Recipients shall be accepted for treatment by the home health agency on the basis of a reasonable expectation that the recipient's health needs may be adequately met by the agency in the recipient's place of residence.

To be covered by the Department for Medicaid Services a service shall be:
(1) Medically reasonable and medically necessary pursuant to 907 KAR 3:130 to the treatment of the recipient's illness or injury;
(2) Effective August 1, 2006, clinically appropriate pursuant to the criteria established via 907 KAR 3:130; and
(3) Reasonable and necessary that the service be provided in the home setting.

All recipients shall have a home health plan of care and medical records which indicate that the above requirements have been met.

A. Eligibility for Services

Home health services are available to eligible Kentucky Medicaid recipients regardless of age. Eligibility of a recipient for home health services does not depend upon his need for or discharge from institutional care. Eligibility for home health aide services shall not be limited to recipients requiring nursing or therapy services. A recipient who requires only home health aide services with the supervision, evaluation, and coordination by the registered nurse, may be considered for coverage. This would include the recipient with limitations due to senility or a psychiatric problem necessitating the provision of aide services. The supervision requirements for home health aide services shall be met, however, with the supervisory visits considered as administrative cost and not directly reimbursable. In order to be eligible to receive medical social services, the recipient must also be receiving either nursing, therapy, or home health aide services (refer to specific service covered section (IV, B) for additional information regarding medical social services.)

SECTION IV - PROGRAM COVERAGE

1. ELIGIBILITY CONSIDERATIONS – CONDITION OF RECIPIENT, SERVICES PROVIDED, AND ABSENCES FROM THE HOME

The Medicaid Home Health Program does not require specifically that the recipient be labeled essentially homebound in order to be eligible to receive home health services. The medical condition of the recipient and the services to be provided shall be considered when determining if it is reasonable to request Medicaid reimbursement for home health services. Recipients may be eligible for home health based on the following considerations:

a. Medical condition of the recipient

The medical condition of the recipient, including whether services are medically necessary pursuant to 907 KAR 3:130 and whether services are clinically appropriate pursuant to 907 KAR 3:130, shall be considered when determining if it is reasonable and necessary to request Medicaid reimbursement for home health services. There shall be a diagnosis of illness or injury and there shall be medical care needs related to that diagnosis. Consideration shall be given to the degree of difficulty the recipient has in getting around and making trips away from his home (e.g. degree of fatigue, shortness of breath, sensory problems, and functional limitations); consideration shall be given to the amount of assistance necessary to transport the recipient; and consideration shall be given to the mental condition of the recipient.

Examples of these considerations would be: a recipient who is paralyzed from a stroke and confined to a wheelchair could require considerable assistance on the part of another person or a special van; a recipient who is blind or senile could require the assistance of another person in leaving his place of residence; the recipient who has returned from a hospital stay involving surgery could be suffering from resultant weakness and pain, and therefore, have had his activities restricted by the physician or by his medical condition; a recipient with arteriosclerotic heart disease of such severity that he must avoid all stress and physical activity; and a recipient with psychiatric problems whose illness is manifested in part by a refusal to leave his home environment or have his illness be of such a nature that it would not be considered safe for him to leave his place of residence unattended even if he has no physical limitations.

b. Services to be Provided

The services to be provided shall also be considered when determining if it is reasonable to request Medicaid reimbursement for home health service. There are instances when it is appropriate that the service be provided in the home setting. There are instances when neither the fact that a recipient is able to be away from his home with difficulty nor the purpose of his trips away from home would have a bearing upon the appropriateness of providing home health services under the Medicaid Program.

Examples of this consideration would be: A recipient requires only personal care service which could be provided by the home health aide; the patient needs to be taught to perform a procedure that most appropriately should be taught in the home setting where the procedure is to be performed, such as colostomy irrigation or self-catherization; prefilling insulin syringes when the recipient is unable to do this and there are no family members who can be taught; or providing medically reasonable and necessary supplies.

c. Absences from the home shall be considered:

Evaluations are to be made of the frequency and purpose of the trips, in light of the services required as a result of the medical condition. Absences from the home for the purpose of receiving medical services do not necessarily preclude the provision of in-home services. Some examples of specific considerations are: a recipient is required to go to dialysis three days a week but also needs diabetic monitoring and insulin syringes filled once a week; a recipient who is very functionally involved needs to go to the hospital outpatient department for physical therapy because of the special equipment available but also needs to continue to receive occupational therapy at home; a recipient requires personal care services which are only available in the home setting.

Absences from the home for educational purposes would not prevent the recipient from receiving home health services if other requirements have been met.

Lack of transportation is not a consideration for seeking Medicaid reimbursement for home health services.

It is not the intent of the Medicaid Program that recipients never leave their home for non-medical reasons. It is recognized that people must be able to leave their homes on occasion even though it does require a considerable and taxing effort.

It is the intent of the program, however, that reimbursement for the more expensive in-home services not be requested if the recipient is able to be away from his home and could receive these services in an outpatient setting. To achieve this objective, a considerable amount of responsibility rests with the home health agency to screen the referrals received and assure that only those recipients who qualify are accepted for services.

2. Definition of Place of Residence

The recipient's place of residence is wherever he makes his home. This may be his own dwelling, an apartment, a relative's home, or a personal care home. An institution which meets the definition of a hospital or nursing facility, shall not be considered as the recipient's home for the purpose of determining coverage for home health services. Additionally, services rendered in a school, day care center, or Head Start center shall not be considered valid places of service. Place of service shall not be a nursing facility for Medicare coinsurance and deductible claims.

3. Plan of Care

Recipients are accepted for treatment on the basis of a reasonable expectation that the recipient's medical, nursing, and social needs can be met adequately by the agency in the recipient's place of residence. Services shall follow a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

The plan of care is developed by the physician in consultation with appropriate professional agency staff. The plan of care shall contain all pertinent diagnoses including the recipient's mental status; services needed, including supplies and equipment required; frequency of visits to be made; prognosis; rehabilitation potential; functional limitations; activities permitted; nutritional requirements; medications and treatments; any safety measures to protect against injury; instructions for timely discharge or referral; and any other appropriate items.

Services provided before the physician signs the plan of care are considered to be provided under a plan established and approved by the physician if there is a verbal order for the care received prior to providing the services and the verbal order is documented in the medical record. The services shall be included in a signed plan of care. If the physician refers a recipient under a verbal plan of care, the agency shall forward its written record to the physician who shall sign and return it to the agency. If the physician refers a recipient under a plan of care that cannot be completed until after an evaluation visit, the physician shall be consulted to approve additions or modifications to the original plan. Any additions or modifications to the original plan of care are to be indicated on a change of order form, signed by the physician and included in the recertification. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency, and duration of the therapy service.

Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff shall check all medicines a recipient may be taking to identify possible ineffective drug therapy or adverse reactions, significant side effects, drug allergies and contraindicated medication, and promptly report any problem to the physician.

The orders on the plan of care shall indicate the type of services to be provided, nature of service, frequency of the service and expected duration. Orders for care can indicate a specific range in the frequency of visits to ensure that the most appropriate level of service is provided. When a range of visits is ordered, the upper limit of the range is to be considered the specific frequency. It is not acceptable for the orders to state 3x per week and PRN. This is not a specific order because the number of weeks is not specified; PRN is open ended; and the nature of the service is not specified. An example of an acceptable order would be 3x per week x4 weeks and PRN x2 to perform a specific service. Orders for therapy services are to include the specific procedures and modalities to be used and the amount, frequency and duration. The therapist and other agency personnel shall participate in developing the plan of care.

It is acceptable to utilize the same plan of care forms required by Medicare or another form which meets all licensure and certification requirements for a plan of care. The status of each recipient and the plan of care shall be reviewed at such intervals as the severity of the recipient's illness requires but no less frequently than every two months, with a maximum of sixty-two (62) days, by home health agency staff and the physician. The physician shall sign and recertify the plan of care no less frequently than every two months, with a maximum of sixty-two (62) days.

B. SPECIFIC SERVICES COVERED

The following services are included as covered services through the home health services element of Medicaid when provided to an eligible recipient in his place of residence and ordered by a physician in a plan of care:

1. Nursing Services

Part-time or intermittent nursing services, as defined in the Kentucky Nursing Practice Act, are covered when provided by a registered nurse or a licensed practical nurse who is under the supervision of a registered nurse, according to the direction of the recipient's physician. The services shall require the skills of a registered nurse or a licensed practical nurse, and shall be reasonable and necessary to the treatment of the patient's illness or injury. Most recipients accepted for home health care will require more than one visit; however, there may be some instances where a single visit is all that is needed. A ONE TIME VISIT FOR GENERAL LABORATORY SCREENING SERVICES, HOWEVER, IS NOT A COVERED SERVICE (FOR EXAMPLE, SERVICES WHICH MIGHT BE PERFORMED ANNUALLY, SEMI-ANNUALLY, OR QUARTERLY FOR PATIENTS IN PERSONAL CARE FACILITIES).

Coverage shall not be available for full-time nursing care under the Kentucky Medicaid Home Health Program. Additionally, coverage for daily nursing visits (except for unusual and complicated situations) is limited to short periods of time. Short periods of time may be defined as up to thirty (30) days. Examples of daily nursing visits would be as follows: daily visits to change a dressing following a surgical procedure or to teach the patient or family; daily visits to give insulin injections during the period of time when the agency is training the recipient or a family member how to administer the injections or when the agency is trying to make arrangements with another person who is able and willing to administer the injections; and administration of IV antibiotic therapy.

a. Standard: Duties of the Registered Nurse.

The registered nurse makes the initial evaluation visit, regularly re-evaluates the recipient's nursing needs, initiates the plan of care and necessary revisions, furnishes those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the recipient's condition and needs, counsels the recipient and family in meeting nursing and related needs, participates in inservice programs, supervises and teaches other nursing personnel and supervises the home health aide.

b. Standard: Duties of the Licensed Practical Nurse.

The licensed practical nurse provides services in accordance with agency policies and the Kentucky Nursing Practice Act, prepares clinical and progress notes, assists the physician and registered nurse in performing specialized procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the recipient in learning appropriate self-care techniques.

c. Specific Guidelines for Nursing Service.

Nursing services shall be medically reasonable and necessary for the treatment of an illness or injury, and shall require that they be performed by or under the direct supervision of a licensed nurse. In determining whether a service requires that it be performed by a nurse, consideration shall be given to the inherent complexity of the services and the medical condition of the recipient. In many instances, the service may be classified as a nursing service on the basis of its complexity alone (i.e. intravenous or intramuscular injections, insertion of a catheter). There are other instances where the nature of the service AND the condition of a recipient would affect whether the service may only be performed safely and effectively by the nurse or is able to be performed by the home health aide or a non-medical person. For example, the giving of a bath does not generally require that it be performed by the licensed nurse. Consequently, it would usually not constitute a covered nursing service even though it may have been performed by a nurse, unless the recipient's condition was of such severity that it would not be safe for the service to be performed by anyone but a nurse.

d. Observation and Evaluation

Nursing visits ordered by the physician for observation and evaluation of the recipient's condition may be covered provided: a reasonable probability exists that significant changes may occur which would require the physician or nurse's service to evaluate the need to change the plan of care; or the recipient's illness has become relatively stabilized but the physician determines a risk of future complications from the illness or injury exists which could require the skilled observation techniques of the nurse. Visits falling into this category would be infrequent; for example, monthly for a limited period of time. Frequent visits when no changes could be anticipated shall not be considered medically reasonable or necessary. Recipients or family members should be taught to observe for signs and symptoms of possible complications which should be reported to the physician or the nurse. If a recipient's condition has not changed for several months, very careful consideration should be given as to the necessity or reasonableness of continuing service.

e. Psychiatric Service

The following guidelines relate to the provision of psychiatric service through the Home Health Program.

It has been determined that supporting services including drawing blood for serum lithium levels, administering Prolixin injections, and monitoring medications for side effects may be covered through the Home Health Program provided that:

(1) Recipient is not an active case of the community mental health center and does not receive chemotherapy from a community mental health center;

(2) Recipient meets the eligibility criteria for home health services;

(3) The service has been ordered by a physician;

(4) The service shall be medically reasonable and necessary.

It is the responsibility of the staff of the home health agency to verify that the recipient is not being followed by the community mental health center, but rather by the referring physician.

Psychiatric services including counseling, psychotherapy or other mental health related services will not be reimbursed under the Home Health Program of the Department for Medicaid Services. Community mental health centers are reimbursed to provide these services either directly or through contractual arrangements with the necessary follow-up required preventing possible fragmentation of services. Home visits are a covered service under the community mental health center program.

To avoid possible duplication of service, the home health agency and the community mental health center would need to enter into contractual arrangements to serve identified psychiatric needs of the area. The community mental health center would continue to be the primary responsible agency and any reimbursement would be through the community mental health center element of the Department for Medicaid Services to the community mental health center.

f. Examples of Some Specific Covered Nursing Services

1. The pre-filling of insulin syringes with monitoring of the recipient's diabetic condition may be a covered service provided there is no one who can be taught to perform this service.

2. Prefilling medication dispensing system when there is no one who can be taught to perform the service.

g. Examples of Non-Covered Nursing Service

1. Nursing visits to perform glucometer testing are not covered as it generally does not require the skills of a nurse to perform these tests.

2. Therapy Services

As appropriate, physical, occupational, or speech therapy may be provided by the home health agency directly or under contractual arrangement by a qualified therapist or a qualified therapist assistant under the supervision of a qualified therapist in accordance with the plan of treatment. (Refer to Medicare Conditions of Participation for Home Health Agencies 42 CFR Part 484.4 for qualifications of therapist and therapist assistant.) The qualified therapist assists the physician in evaluating the level of function, helps develop the plan of treatment (revising as necessary), prepares clinical and progress notes, advises and consults with other agency personnel and participates in inservice programs.

A recipient may qualify under Medicaid requirements if any one of the therapy services is needed, provided that the eligibility requirements for Home Health Service are met. Refer to Eligibility Services Section IV, A., pages 4.1-4.4.

a. Physical therapy shall include:

(1) Assisting the physician to evaluate the recipient for physical therapy through the application of muscle, nerve, joint and functional ability tests;

(2) Therapeutic exercise program by therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion;

(3) Gait evaluation and training;

(4) Transfer training and instructions in care and use of wheelchairs, braces, prosthesis, etc;

(5) Instruction in breathing exercises, percussion, postural drainage, vibration for pulmonary functioning;

(6) Teaching compensatory technique to improve the level of independence in activities of daily living; and

(7) Training and instructions for patient or family in setting up and following a physical therapy program.

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist. A maintenance program shall be developed for the performance of simple procedures which could be safely and effectively provided by the recipient, family or home health aide.

b. Occupational therapy shall include:

(1) Assisting the physician to evaluate the recipient for occupational therapy services through the appropriate testing technique;

(2) Therapeutic exercise program provided by the therapist including muscle strengthening, neuromuscular facilitation, sitting and standing balance and endurance, and increased range of motion;

(3) Assisting recipients to obtain better coordination, use of senses and perception

(4) Instructing the recipient or family in setting up and following an occupational therapy program;

(5) Teaching compensatory technique to improve the level of independence in activities of daily living; and

(6) Designing and fitting orthotic and self-help devices (i.e., hand splints for the recipient with rheumatoid arthritis).

The services shall be reasonable and necessary for the recipient's condition and shall be of such complexity that they must be performed by the qualified therapist.

c. Speech pathology shall include:

(1) Assisting the physician to evaluate the recipient for speech pathology service through the appropriate testing techniques;

(2) Determining and recommending appropriate speech, language, hearing, dysphagia and oral feeding services;

(3) Providing necessary rehabilitative services for recipients with speech, hearing, language, dysphagia and oral feeding disabilities.

(4) Instructing the recipients and family in setting up and following a speech pathology program.

The services shall be reasonable and necessary for the recipient's condition and of such complexity that they must be performed by the qualified therapist.

3. Home Health Aide Services

The home health aide provides services in accordance with the care plan and under the written instructions for recipient care and supervision provided by the registered nurse or therapist, as appropriate. Home health aide service may be provided directly by the home health agency and by contractual arrangements. The duties of the aide include: the performance of simple procedures as an extension of therapy services; personal care (i.e. bathing, shampoo, special foot care); range of motion exercises and ambulation; assistance with medications that are ordinarily self-administered and which have been specifically ordered by the physician; reporting changes in the recipient's condition and needs; and completing appropriate records. The home health aide may also perform incidental household services which are essential to the recipient's health care at home WHEN PROVIDED IN THE COURSE OF A REGULAR VISIT (i.e., straightening room, or changing linens). Domestic or housekeeping services which are unrelated to the recipient's care are not covered under the Medicaid Home Health Program.

SECTION IV - SERVICES COVERED

In order for the services of the home health aide to be considered reasonable and necessary, they must be services that the recipient is either physically or mentally unable to do for himself. It shall not be considered reasonable and necessary for Medicaid to pay for services which the recipient can perform for himself but chooses not to perform.

Medicaid home health services are designed to address the needs of the long-term, chronically ill recipient as well as the needs of the short-term, acutely ill recipient. For example, the recipient who mainly needs services of the home health aide, with the supervision, evaluation and coordination by the registered nurse, may be considered for coverage under the home health program.

SUPERVISION: The registered nurse or Licensed Physical Therapist if physical therapy services are provided, shall make a supervisory visit to the recipient's residence at least every two weeks, either when the aide is present to observe and assist, or when the aide is absent, to assess relationships and determine whether goals are being met.

Visits made to evaluate the aide services or to supervise or instruct the home health aide are considered (as) administrative costs and are not directly reimbursable.

TRAINING OF HOME HEALTH AIDES: The home health agency shall be responsible for assuring that the home health aide meets the training and competency evaluation or a competency evaluation requirements as outlined in Conditions of Participation for Home Health Agencies in 42 CFR Part 484.

4. Medical Social Services

Medical social services are a covered service when provided under the direction of the physician's plan of care by a qualified medical social worker or a qualified social work assistant under the direction of a qualified social worker, as defined by the Medicare Program: Home Health Agencies: Conditions of Participation.

Responsibilities of the social worker are to:

a. assist the physician and other team members in understanding the significant social and emotional factors related to the health problems;

b. participate in the development of the plan of care;

c. prepare clinical and progress notes;

d. assist the recipient and family to understand, accept, and follow medical recommendations;

e. assist recipient and family to recognize and change personal and environmental difficulties which predispose toward illness or interfere with obtaining maximum benefit from medical care;

f. evaluate the need for and utilize other support resources available within the community to enable the recipient to remain at home;

g. participate in discharge planning and inservice programs;

h. act as a consultant to other agency personnel.

A recipient requiring **ONLY** medical social services shall not meet Medicaid home health guidelines for coverage. If a recipient has been accepted for home health care under a plan of care for medical social services in addition to other services (nursing, therapy or home health aide), coverage may continue for completing the social work plan after the recipient's care plan has been closed to other services, provided a recertification is not due. A recipient shall not be recertified for medical social services only.

5. Disposable Medical Supplies

Disposable medical supplies are a covered home health service. Payment may be made for those medical supplies which are essential in providing the treatment which the physician has ordered for the recipient and which are in keeping with accepted medical practice. The plan of care or recertification shall support the need for the supplies. When appropriate, the specific items and directions for use must be included as part of the physician's plan of care and recertification.

Supplies, such as syringes, which are relatively inexpensive and are needed frequently in the treatment of a recipient, are billed collectively by the type of supply used. If the supplies are rarely used, they should be considered part of the routine or "bag supplies" and are to be included as administrative cost. The necessity for one swab, one band-aid or one 4 x 4 bandage should not initiate a request for payment.

Program funds have prohibited the indiscriminate reimbursement for supplies from which the recipient might benefit. Reimbursement shall be limited to the supplies actually used on the recipient and considered within the norm of accepted practice. For example, an apron used by the nurse, for protection of both the nurse and recipient, is not used on the recipient as a part of the treatment, therefore, it shall not be considered as a covered medical supply. Gloves that are used in treatment of an open wound requiring extensive handling of dressings, which would be impractical to do with sterile forceps to prevent contamination, are considered reimbursable; however, gloves used for protection of the nurse or aide shall not be billable as a covered medical supply, but are an allowable administrative cost.

The cost of supplies for personal hygiene is considered outside the services covered under the home health program. Examples of items considered as used for personal hygiene would be; soap, shampoo, toothpaste, toothbrush, wash cloths, towels, deodorant, and shaving lotion. Therapeutic supplies including lotions or powders used in rendering nursing care to a bedfast recipient are considered as reimbursable items, if deemed essential in providing the degree of care which the physician has ordered for the bedfast recipient.

In the event a recipient is not in need of home health visits but has a condition that requires disposable medical supplies to maintain him in the home, vendor payment may be made under the home health program. The procedures required for coverage of these supplies through the home health agency will be as follows:

The physician shall certify that the disposable medical supplies are medically required. The physician is to sign and date a completed Certification for Medical Supply Form (MAP-248). There may be instances where the physician orders supplies on another type of form such as a prescription form. It shall still be necessary for the agency to have the physician sign and date the completed Certification for Medical Supply Form. A new physician's certification is to be completed and signed every 6 months or earlier if a change occurs in supplies requested.

When the services provided are limited to disposable medical supplies, it is not required that the agency open a complete recipient record. However, records shall be maintained which include the physician's certification and orders, and any other pertinent information.

The UB-82 (HCFA-1450) is to be completed in the usual manner.

Examples of Covered Supplies Include But are Not Limited To:

-Adapters;
-Applicators;
-Drainage supplies;
-Dressing supplies;
-Catheter, ileostomy and ureostomy supplies;
-Colostomy supplies;
-Detection reagents for other than sugar or ketone;
-Diapers, underpads and incontinent pants (not covered before age 3);
-Egg crate mattress;
-Enema and elimination supplies including fleets enema or dulcolax suppos tory;
-Gastrostomy supplies;
-Gloves (clean or sterile);
-Inhalation therapy supplies;
-Irrigation solutions;
-IV therapy supplies including solutions unless a drug has been added to the solution by the pharmacy in which case it should be billed by the pharmacy;

-Lambs wool pads or synthetic pads;
-Lotions - powders - cream (invalid or bedfast patient);
-Nipples (specially designed for cleft palate only);
-Inexpensive occupational therapy supplies including plastic utensil holder and long arm reacher;
-Suction supplies;
-Support supplies including antiembolism stockings, support vest, support gauntlet, or support glove;
-Syringes and needles (excluding insulin syringes for diabetic);
-Tracheostomy supplies;
-Tubing.

*DRUGS - NOTE: Drugs are not included as disposable medical supplies.

Payment is made by Medicaid for covered drugs through the pharmacy program. The drugs are included on the Medicaid Drug List or approved by the special Drug Pre-authorization Project. Please refer to Appendix XII for a copy of "Drug Preauthorization Policies and Procedures" from Pharmacy Services Manual. The telephone number for Drug Preauthorization is (800) 756-7558 (in-state) and (502) 227-9073 (out of state).

6. Enteral Nutritional Products

Coverage shall be available through the Home Health Program for enteral nutritional products. Enteral nutritional products may be either ingested orally or delivered by tube into the gastrointestinal track. Coverage shall be available for enteral nutritional products which provide for the total nutrition of the recipient or for supplemental nutrition. However, these products shall be covered when provided as an integral part of a treatment plan which the physician has ordered for the recipient. The recipient shall also be receiving covered home health visits by at least one of the following disciplines; nursing, home health aide, physical therapy, speech therapy, or occupational therapy. These visits may be covered by Medicare, Medicaid, or an insurance policy. Coverage for enteral nutritional products shall not be available as a "stand alone" service as is possible for disposable medical supplies.

The revenue code for enteral nutritional products is 279. For reporting purposes, these items shall report in the general disposable medical supply category and be subject to the same reimbursement principles and interim reimbursement rate established for disposable medical supplies.

C. Exclusions from Coverage (Services and Supplies)

The following services and supplies are excluded from coverage under the Department for Medicaid Services home health program:

1. Domestic or housekeeping services which are unrelated to recipient care;

2. Transportation services, i.e. from place of residence to a facility to receive services;

3. Drugs;

4. Newborn or post-partum service without the presence of medical complications except for the first week following a home delivery;

5. Disposable diapers shall not be covered before the recipient is 3 years of age regardless of medical condition. Age 3 and over disposable diapers are covered if medical condition and diagnosis indicate the need;

6. Services for which the recipient has no obligation to pay and for which no other person has a legal obligation to pay.

D. Hospice Service Relation To Home Health

Home health services are not covered for recipients who have elected to receive Medicare or Medicaid Hospice care when the service provided IS related to the terminal condition;

When the service to be provided by the home health agency is NOT related to the terminal illness an arrangement shall be made between the hospice provider and the home health agency. In that case, the hospice provider would notify Medicaid and request approval for the home health service. A MAP-397 shall be sent to the home health agency by the hospice provider and the home health agency shall attach the MAP-397 to the home health bill for that particular approved service.)

E. End Stage Renal Disease (ESRD) Services Relation to Home Health

Payments shall not be made through the Home Health Program for services provided in the home to end stage renal disease recipients (ESRD) receiving dialysis either at the dialysis clinic or at home. If the care provided to the recipient is dialysis related, that care is the responsibility of the ESRD facility. An example would be treating an infected shunt site or epogen injection. Home health services which are not ESRD-related may be considered for the home health recipient who is also receiving dialysis. Examples would be treating an abandoned shunt site or decubitus wound care.

C. Duplicate or Inappropriate Payments

Any duplicate or inappropriate payment by Medicaid, whether due to erroneous billing or payment system faults, shall be refunded to Medicaid. Sufficient documentation and explanation of refund shall be attached to the refund check in order to process the refund correctly. Refund checks should be made payable to "Kentucky State Treasurer" and sent immediately to:

EDS
P.O. Box 2009
Frankfort, KY 40602

ATTN: Cash/Finance Unit

Failure to refund a duplicate or inappropriate payment could be interpreted as fraud or abuse, and prosecuted as such. Please refer to Section X, General Information-EDS, for further information.

D. ADJUSTMENT

An incorrect payment of an entire claim or line item would need to be corrected through the adjustment process, and would not be refunded unless the entire amount was billed in error. Please refer to Section X, General Information-EDS, for further information.

E. Kentucky Patient Access and Care System (KenPAC)

KenPAC is a statewide patient care system which, as an adjunct to the Kentucky Medicaid Program, provides certain categories of medical recipients with a primary physician or family doctor. Only those recipients who receive Medicaid under the Aid to Families with Dependent Children (AFDC), or AFDC-related categories are covered by KenPAC. Specifically excluded are: the aged, blind, and disabled categories of recipients; nursing facility (NF) and personal care (PC) residents; mental hospital patients; foster care cases; refugee cases; all spend-down cases; and all Lock-In cases. To aid in distinguishing from regular Medicaid recipients, the KenPAC recipients will have a color-coded Medicaid card with the name, address, and telephone number of their primary care provider.

Primary physician specialists or groups who may participate as primary physicians are:

General Practitioners	Obstetricians	Primary Physician Clinics
Family Practitioners	Gynecologists	Primary Care Centers
Pediatricians	Internists	Rural Health Clinics

Recipients may select a primary physician or clinic who agrees to participate in Medicaid and KenPAC. Recipients not selecting a primary physician will be assigned one within their home county. A primary physician may serve up to 1,500 KenPAC recipients. Provider clinics may serve up to 1,500 recipients for each full-time equivalent physician. Primary Care Centers and Rural Health Clinics may also be assigned recipients based on the number of Registered Nurse Practitioners they have on staff.

SECTION V - REIMBURSEMENT

KenPAC primary physicians and clinics must arrange for physician coverage 24 hours per day, seven days per week. A single 24 hour access telephone number must be provided by the primary physician or clinic. This number will be printed on the recipient's KenPAC Medical Assistance Identification Card.

The following service categories shall be either provided by the primary physician or clinic or referred by the primary physician or clinic in order to be reimbursed by Medicaid.

Physician (excludes ophthalmologists and psychiatrists)
Hospital (Inpatient) (excludes psychiatric and obstetrical admissions)
Hospital (Outpatient)
Laboratory Services
Nurse Anesthetists
Rural Health Clinic Services
Home Health
Primary Care Centers
Ambulatory Surgical Centers
Durable Medical Equipment

Obstetrical care, routine newborn care, and other Medicaid covered services not included in the above list may be provided for the KenPAC recipients without prior authorization. The recipient's MAID card lists programs which are not regulated by the KenPAC system.

Services not included in the above list may be obtained by the KenPAC recipient in the usual manner.

SECTION VI - REIMBURSEMENT IN RELATION TO MEDICARE

VI. REIMBURSEMENT IN RELATION TO MEDICARE

A. General Information

The Medicare Program shall be billed for services which would be covered by the Medicare Program. The Medicaid program shall not be billed for services which could have been covered by the Medicare Program. It is the responsibility of the home health agency to keep abreast of current Medicare coverage guidelines and bill according to the guidelines.

1. Deductible and Coinsurance

a. The Medicaid Program will make payment to the home health agency for the Medicare deductible and coinsurance due for services provided by the home health agency.

Services, including therapies, provided in a nursing facility are excluded from coverage. This will be edited through post-payment review.

2. Billing Instructions

a. All necessary billing should be completed with the Medicare Intermediary before any billing is submitted to EDS.

b. Upon receipt of Medicare's Remittance Advice, the home health agency may bill EDS for the deductible and coinsurance amount due for a Medicaid eligible recipient.

All Medicare deductible and coinsurance claims must be billed on a UB-82 claim form with a copy of the Medicare Remittance Advice attached.

c. There may be several recipients listed on the Medicare Remittance Advice. It is necessary to make a copy of the Medicare Remittance Advice to attach to the completed UB-82 claim form submitted to EDS. The recipient information on the Medicare Remittance Advice for which the Medicare billing statement is applicable MUST be underlined in RED.

B. Recipients who are eligible for Medicare but the services have been rejected by the Medicare Intermediary

A MAP-34 shall be completed and kept as a part of the recipient's record whenever a recipient has been rejected by Medicare and the agency will be billing the Medicaid Program for services provided. The MAP-34 block which is Block 87 on the UB-82 shall be marked with a Y to indicate that the MAP-34 is available in the recipient's record. A new MAP-34 shall be completed whenever the reason changes or at least every 12 months.

C. Reimbursement for a recipient who is eligible for Medicare when it has been determined by Utilization Review that the services would not be covered under the Medicare Program.

A MAP-34 shall be completed and kept as a part of the recipient's record whenever a recipient has been rejected by Utilization Review and the agency will be billing the Medicaid Program for services provided. The MAP-34 block which is Block 87 on the UB-82 must be marked with a Y to indicate that the MAP-34 is available in the recipient's record. A new MAP-34 shall be completed whenever the reason changes or at least every 12 months.

It is emphasized again that the Medicare Program has the primary liability to cover those services which meet the Medicare Program guidelines. The Medicaid Program has the secondary liability in relation to Medicare.

SECTION VII - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

VII. REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

A. General Information

1. General

To expedite the Medicaid claims processing payment function, the provider of Medicaid services shall actively participate in the identification of third party resources for payment on behalf of the recipient. At the time the provider obtains Medicaid billing information from the recipient, it shall be determined if additional resources exist. Providers have an obligation to investigate and to report the existence of other insurance or liability. The provider's cooperation will enable the Kentucky Medicaid program to function efficiently.

2. Identification of Third Party Resources

Pursuant to KRS 205.662, prior to billing the Kentucky Medicaid Program, all participating providers shall submit billings for medical services to a third party when the provider has prior knowledge that a third party may be liable for payment of the services.

In order to identify those recipients who may be covered through a variety of health insurance resources, the provider should inquire if the recipient meets any of the following conditions:

- -If the recipient is married or working, inquire about possible health insurance through the recipient's or spouse's employer;
- -If the recipient is a minor, ask about insurance the MOTHER, FATHER, OR GUARDIAN may carry on the recipient;
- -In cases of active or retired military personnel, request information about CHAMPUS coverage and social security number of the policy holder;
- -For people over 65 or disabled, seek a MEDICARE HIC number;
- -Ask if the recipient has health insurance such as a MEDI CARE SUPPLEMENT policy, CANCER, ACCIDENT, or INDEMNITY policy, GROUP health or INDIVIDUAL insurance, etc.

Examine the recipient's MAID card for an insurance code. If a code indicates insurance coverage, question the recipient further regarding the insurance.

Following is a list of the insurance codes on the MAID card:

A - Part A, Medicare only
R - Part A, Medicare Premium Paid
B - Part B, Medicare only
C - Both Parts A and B Medicare
S - Both Parts A and B Medicare Premium Paid
D - Blue Cross/Blue Shield
E - Blue Cross/Blue Shield/Major Medical
F - Private medical insurance
G - Champus
H - Health Maintenance Organization
J - Unknown
K - Other
L - Absent Parent's insurance
M - None
N - United Mine Workers
P - Black Lung

B. Billing Instructions for Claims Involving Third Party Resources

The home health agency shall complete all billing with the third party payer prior to billing EDS. After payment has been received from the third party payer, the home health agency should complete a UB-82 claim as if they were preparing a regular home health claim. They shall enter all of the services billed to the third party payer using applicable revenue codes. Separate services shall be entered on separate lines of the billing form as they would be entered on the regular home health claim. The agency shall enter the total charges on the claim in Block #53.

(Total Claim Charge); enter the amount received from the third party payer in Block #63 (Prior Payment).

NOTE: Effective with service dates of July 1, 1989, and after, no payment shall be made for any deductible or coinsurance amounts due for durable medical equipment, braces, or prosthetics incurred as the result of billing an insurance company.

C. Forms of Documentation That Will Prevent a Claim From Denying For Other Insurance:

The following forms of documentation when attached to the claim will prevent your claim from denying because of other health insurance:

1. Remittance statement from the insurance carrier that includes:

   a. Recipient Name

   b. Date(s) of service

   c. Billed information that matches the billed information on the claim submitted to Medicaid.

   d. An indication of denial or that the billed amount was applied to the deductible.

   NOTE: Denials from insurance carriers stating additional information necessary to process claim are not acceptable.

2. Letter from the insurance carrier that includes:

   a. Recipient Name

   b. Date(s) of services

   c. Termination or effective date of coverage

   d. Statement of benefits available (if applicable)

   e. Signature of insurance representative or the letter must be on the insurance company's letterhead.

3. Letter from a provider that states their office contacted the insurance company by phone and provides the following information:

   a. Recipient Name

   b. Date(s) of service

   c. Name of Insurance Carrier

   d. Name of Insurance Representative spoken to and their phone number (or notation indicating a voice automated response system was reached)

   e. Termination or effective date of coverage

   f. Statement of benefits available (if applicable)

4. A copy of a prior remittance advice from an insurance company, can be considered an acceptable form of documentation if it is:

   a. for the same recipient

b. for the same or related service being billed on the claim

c. the date of service specified on the remittance advice is no more than six (6) months prior to the claim's date of service

If the remittance advice does not provide a date of service then the denial can only be acceptable by EDS if the date of the remittance advice is no more than six (6) months from the claim's date of service.

D. How Other Health Insurance Information Documentation Sent With Claims Is Used To Update Medicaid's Recipient Eligibility Files

When a claim is received for a recipient whose eligibility file indicates other health insurance that is active and applicable for the dates of services, types of service being billed and no payment from other sources is entered on the Medicaid claim form, the claim is automatically denied; unless documentation is attached.

EDS will review any documentation attached to a claim to determine whether it meets the above described criteria so that they can avoid denying a claim because of the recipient's other health insurance.

If the documentation is acceptable, copies of the documentation are made and forwarded to the third party unit at EDS.

If the documentation is from the insurance company, EDS will update the recipient's eligibility file to reflect the correct dates of coverage, type of coverage, etc.

When EDS receives documentation that is sufficient to process your claim, but is missing information needed to update the recipient file such as the specific date of termination, a questionnaire is sent to the insurance carrier asking them to supply the missing information. The recipient's file cannot be updated until a response is received from the insurance carrier, so all claims for the recipient will continue to require that documentation be attached.

When EDS receives copies of any documentation that does not include written verification from the insurance carrier of the change, a questionnaire is sent to the insurance carrier asking them to verify the change requested in the provider's letter. The recipient's file cannot be updated until a response is received from the insurance carrier, so all claims for the recipient will continue to require that documentation be attached. This is why it is best to submit written verification from the insurance carrier so that not only can the claim be processed, but the recipient's file can be updated promptly.

E. When You Bill the Insurance Carrier and Cannot Receive a Response Within 120 Days.

Another situation that may occur is when the other health insurance has not responded to a provider's billing within 120 days from the date of filing a claim. This process can only be used if a provider has "no response" and should not be used if a response has been received, but no payment has been.

Complete a TPL Lead Form and write "No Response in 120 Days" on either the TPL Lead Form or the claim form, attach it to the claim and submit it to EDS. EDS will override the other health insurance edits and forward a copy of the TPL Lead Form to their Third Party Unit who will contact the insurance carrier to see why they have not paid their portion of liability.

F. Accident and Work Related Claims

For claims billed to Medicaid that are related to an accident or work related incident, the provider shall pursue information relating to the accident. If an employer, individual or an insurance carrier is a liable party, but the liability has not been determined, you may proceed with submitting your claim to EDS if you provide any information obtained; the names of attorneys, other involved parties and the recipient's employer to:

EDS
P.O. Box 2009
Frankfort, KY 40602
ATTN: TPL Unit

If you have any questions concerning how to submit your claims when other insurance is involved you may contact the EDS Provider Relations Unit at 1-800-756-7557 for assistance.

G. Medicaid Payment for Claims Involving a Third Party

Claims meeting the requirements for Medicaid Program payment shall be paid in the following manner if a third party payment is identified on the claim.

The amount paid by the third party shall be deducted from the Medicaid allowed amount and the difference paid to the provider. If the third party payment amount exceeds the Medicaid allowed amount, the resulting Medicaid payment will be zero. Recipients may not be billed for any difference between the billed amount and Medicaid payment amount. Providers shall accept Medicaid payment as payment in full.

SECTION VII - REIMBURSEMENT IN RELATION TO OTHER THIRD PARTY COVERAGE (EXCLUDING MEDICARE)

If the claims for a recipient are payable by a third party resource which was not pursued by the provider, the claim will be denied. Along with a third party insurance denial explanation, the name and address of the insurance company, the name of the policy holder, and the policy number will be indicated. The provider shall pursue payment with this third party resource before billing Medicaid again.

If you have questions, please write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602, Attention: Third Party Unit, or call (800) 756-7557 (In-State) or (502) 227-2525.

SECTION VIII - COMPLETION OF INVOICE FORM

VIII. COMPLETION OF INVOICE FORM

A. General

The UB-82 (HCFA-1450) is used to bill for services rendered by a home health agency to eligible Medicaid recipients. Typing of the invoice form is strongly urged, since an invoice cannot be processed and paid unless the information supplied is complete and legible.

The original of the two part invoice set should be submitted to EDS as soon as possible after service is provided. The carbon copy of the invoice should be retained by the provider's office as a record of claim submittal.

Invoices should be mailed to:

EDS
P.O. Box 2045
Frankfort, Kentucky 40602

1. General Billing Instructions

a. The UB-82 (HCFA-1450) shall be used in billing for all covered services provided to eligible Medicaid recipients.

SECTION VIII - COMPLETION OF INVOICE FORM

b. Claims for covered services shall be received by EDS within twelve (12) months from the date of service. Claims with service dates more than twelve (12) months old may be considered for processing only with appropriate documentation such as one or more of the following: Remittance Statements no more than 12 months of age which verify timely billing; backdated MAID cards with "Backdated Card" written on the attached claim; Social Security documents; correspondence describing extenuating circumstances; Action Sheets, Return to Provider Letters; Medicare Explanation of Medical Benefits, etc.

c. A single billing statement shall not include services provided in different calendar months.

d. Services provided in different fiscal years of the agency SHALL be billed on separate billing statements.

e. A separate billing statement shall be used for each recipient.

f. A separate line shall be completed for each covered home health service. A single billing statement may include charges for more than one home health service.

g. The type of bill for the home health program is 331.

h. The UB-82 (HCFA-1450) shall be completed in duplicate. The original is to be forwarded to EDS and the copy is to be retained for the agency's file.

i. The Medicaid recipient's Medical Assistance Identification Card should be examined each time home health services are provided or at least monthly to assure that the home health agency has the correct spelling of the recipient's name and the correct Medical Assistance Identification Number (MAID Number). The home health agency should ascertain that the recipient was eligible for service on the dates that the services were provided and that the name and MAID number entered on the billing statement are exactly as they appear on the current Medical Assistance Identification Card.

B. Completion of the UB-82 (HCFA-1450)

An example of a UB-82 (HCFA-1450) is shown in the appendix. Instructions for the proper completion of this form are presented below.

BLOCK NO.	ITEM DESCRIPTION
1	PROVIDER NAME, ADDRESS, AND TELEPHONE NUMBER Enter the complete name and address of the provider. The telephone number, including area code, is desired.
3	PATIENT CONTROL NUMBER Enter the patient control number assigned by the provider. The first seven digits will appear on the Remittance Statement as the invoice number.

SECTION VIII - COMPLETION OF INVOICE FORM

4 TYPE OF BILL

Enter the appropriate 3 digit code to indicate the type of bill. The type of bill for Home Health Services is 331.

8 MEDICAID PROVIDER NUMBER

Enter the provider's 8 digit provider number assigned by Kentucky Medicaid.

15 ADMISSION DATE

Enter the date on which the recipient was admitted to the Home Health Program in month, day, year sequence and in numeric format. For example: 01/03/92.

21 PATIENT STATUS CODE

Enter the appropriate 2 digit patient status code indicating the disposition of the recipient as of the "through" date in item #22.

Code Structure
01 - Discharge-Home
02 - Discharge to Hospital
03 - Discharge to Nursing Facility - NF
20 - Expired
30 - Still patient of this agency

22 STATEMENT COVERS PERIOD

Enter the "from" and "through" date in numeric month, day and year format. The billing period cannot exceed one calendar month per claim.

SECTION VIII - COMPLETION OF INVOICE FORM

28 OCCURRENCE CODES AND DATES

If the services rendered were required as the result of an accident, enter an 01 in this block; otherwise, leave blank.

44 SPECIAL PROGRAM INDICATOR

Enter an 01 if the services were provided as direct consequence of the recipient being referred to you as the result of an Early and Periodic Screening, Diagnosis and Treatment examination.

45 REFERRING PROVIDER'S MEDICAID NUMBER

Referring provider's number is required for KenPAC recipients. Enter the 8-digit Kentucky Medicaid number of the referring KenPAC provider.

50 DESCRIPTION

Enter the standard abbreviations assigned to each revenue category.

51 REVENUE CODES

Enter the 3 digit code identifying specific services. The Kentucky Medicaid Program covered revenue codes are as follows:

SERVICE	REVENUE CODE
Disposable Medical Supplies	270
Nutritional Enteral Products	279
Physical Therapy	420
Occupational Therapy	430
Speech Therapy	440
Nursing	550
Medical Social Service	560
Home Health Aide	570
Total	001

SECTION VIII - COMPLETION OF INVOICE FORM

52 UNITS

Enter the quantitative measure of services provided per revenue code.

53 TOTAL CHARGES

Enter the total charges pertaining to the related revenue codes for the billing period. The detailed amounts, by revenue codes, must equal the entry "total charges". Revenue code 001 shall be the final entry in column 53.

57 PAYER IDENTIFICATION

Enter the names of payer organizations from which the provider expects payment. All other liable payers, including Medicare, shall be billed first.

*The Medicaid Program is payer of last resort.

60 DEDUCTIBLE (MEDICARE CROSSOVER CLAIMS)

Enter the amount as shown on the Medicare EOMB to be applied to the recipient's deductible amount due. Attach Medicare Documentation.

61 CO-INSURANCE (MEDICARE CROSSOVER CLAIMS)

Enter the amount as shown on the Medicare EOMB to be applied toward the recipient's coinsurance amount due. Attach Medicare Documentation.

63 PRIOR PAYMENTS

Enter the amount the provider has received toward payment of the account prior to the billing date. Spend-down amount and third party payment shall be entered in this area. Do not enter the Medicare payment.

SECTION VIII - COMPLETION OF INVOICE FORM

65 INSURED'S NAME

Enter the insured's name in 65 A, B and C that relates to the payer in 57 A, B and C. Enter the recipient's name exactly as it appears on the Medical Assistance Identification (MAID) card in last name, first name, and middle initial format.

68 IDENTIFICATION NUMBER

Enter the insured's identification number in 68 A, B and C that relates to the insured's name in 65 A, B and C. Enter the 10 digit Medical Assistance identification number exactly as it appears on the Medical Assistance Identification (MAID) card.

77 PRINCIPAL DIAGNOSIS CODE

Enter the ICD-9-CM, Vol. 1 and 2 code describing the principal diagnosis.

78-81 OTHER DIAGNOSIS CODES

Enter the ICD-9-CM, Vol. 1 and 2 codes that co-exist at the time the service is provided.

87 PRO - MAP-34 INDICATOR

Enter a "Y" whenever a MAP-34 form has been completed in relation to the services billed on the UB-82 and is available in the recipient's record.

95 PROVIDER CERTIFICATION AND SIGNATURE

The actual signature of the provider's authorized representative is required. Stamped or typed signatures are not accepted.

96 DATE BILL SUBMITTED

Enter the date in month, day, year numeric format that the UB-82 form was completed and signed.

SECTION VIII - COMPLETION OF INVOICE FORM

C. Billing Instructions for Claims with Service Dates Over 1 Year Old

Medicaid claims shall be filed within one year of the date of service. Medicaid and Medicare crossovers shall be filed within one year of the date of service OR within six months of the Medicare Adjudication Date, whichever is longer. To process claims beyond this limit you shall attach, to EACH claim form involved, a copy of an in-process or denied claim remittance, no more than 12 months of age, which verifies that the original claim was submitted within 12 months of the service date.

Copies of previously submitted claim forms, providers' in-house records of claim submittal, letters which merely detail filing dates are NOT acceptable documentation of timely billing. Attachments must prove that the claim was RECEIVED timely by EDS.

If a claim is being submitted after twelve months from the date of service, due to the recipient's retroactive eligibility, a copy of the backdated or retroactive MAID card shall be attached to the invoice.

Please note on the claim the words "Backdated Eligibility" or "Retroactive Eligibility."

SECTION VIII - COMPLETION OF INVOICE FORM

D. Electronic Media Claims (EMC)

Electronic Media Claims (EMC) is a means by which Home Health providers may submit claims electronically. EMC enables providers to experience an improved cash flow, fewer errors in claims processing, and a reduction in effort with claim preparation. Claims may be submitted electronically in a variety of different ways such as via magnetic tape, diskette, or modem.

Claims that require attachments shall not be submitted electronically.

For more information regarding EMC, contact an EMC Representative at (502) 227-2525 or 1-800-756-7557. You may also write to EDS, P.O. Box 2009, Frankfort, Kentucky 40602.

SECTION IX - REMITTANCE STATEMENT

IX. REMITTANCE STATEMENT

A. General

The EDS Remittance Statement (Remittance Advice) furnishes the provider with an explanation of the status of those claims EDS processed. The Remittance Statement accompanies the payment check and is divided into six sections.

The first section provides an accounting of those claims which are being paid by the Medicaid Program with the accompanying payment check.

The second section provides a list of claims which have been rejected (denied) in total by the Medicaid Program with the corresponding Explanation of Benefit (EOB) code.

The third section provides a list of claims EDS received which did not complete processing as of the date indicated on the Remittance Statement.

The fourth section provides a list of claims received by EDS that could not be processed as the result of incomplete claim information. These claims have been returned to the provider along with a cover letter that explains the reasons for the return.

The fifth section includes the summation of claims payment activity as of the date indicated on the Remittance Statement and the year-to-date claims payment activities.

The sixth section provides a list of EOB codes which appeared on the dated Remittance Statement with the corresponding written explanation of each EOB code.

Claims appearing in any section of the Remittance Statement will be in alphabetical order according to the patient's last name.

B. Section I - Claims Paid

An example of the first section of the Remittance Statement is shown in Appendix IX P.1. This section lists all those claims for which payment is being made. On the pages immediately following are item-by-item explanations of each individual entry appearing on this section of the Remittance Statement.

EXPLANATION OF REMITTANCE STATEMENT FOR
HOME HEALTH SERVICES

ITEM	DEFINITION
INVOICE NUMBER	The preprinted invoice number (or patient account number) appearing on each claim form is printed in this column for the provider's reference.
RECIPIENT NAME	The name of the recipient as it appears on the Department's file of eligible Medicaid recipients.
RECIPIENT NUMBER	The Medical Assistance I.D. Number of the recipient as shown on the claim form submitted by the provider.
INTERNAL CONTROL NO.	The internal control number (ICN) assigned to the claim for identification purposes by EDS.
CLAIM SVC DATE	The earliest and latest dates of services as shown on the claim form.
TOTAL CHARGES	The total charges billed by the provider for services on this claim form.

SECTION IX - REMITTANCE STATEMENT

CHARGES NOT COVRD	Any portion of the provider's billed charges that are not being paid (examples: rejected line item, reduction in billed amount to allowed charge).
AMT. FROM OTHER SRCS	The amount indicated by the provider as received from a source other than the Medicaid Program for services on the claim.
CLAIM PMT AMOUNT	The amount being paid by the Medicaid Program to the provider for this claim.
EOB	For explanation of benefit code, see back page of Remittance Statement.
LINE NO.	The number of the line on the claim being printed.
PS	Place of service code depicting the location of the rendered service.
PROC	The HCPCS procedure code in the line item.
QTY	The number of procedures or supply for that line item charge.
LINE ITEM CHARGE	The charge submitted by the provider for the procedure in the line item.
LINE ITEM PMT	The amount being paid by the Medicaid Program to the provider for a particular line item.
EOB	Explanation of benefit code which identifies the payment process used to pay the line item.

C. Section II - Denied Claims

The second section of the Remittance Statement appears whenever one or more claims are rejected in total. This section lists all those claims and indicates the EOB code explaining the reason for each claim rejection. Appendix IX P.2.

All items printed have been previously defined in the description of the paid claims section of the Remittance Statement.

D. Section III - Claims in Process

The third section of the Remittance Statement (Appendix IX P.3) lists those claims which have been received by EDS but which were not adjudicated as of the date of this report. A claim in this category usually has been suspended from the normal processing cycle because of data errors or the need for further review. A claim appears in the Claims in Process section of the Remittance Statement as long as it remains in process. At the time a final determination can be made as to claim disposition (payment or rejection) the claim will appear in Section I or II of the Remittance Statement.

E. Section IV - Returned Claims

The fourth section of the Remittance Statement (Appendix IX P.4) lists those claims which have been received by EDS and returned to the provider because required information is missing from the claim. The claim has been returned to the provider with a cover sheet which indicates the reason(s) that the claim has been returned.

F. Section V - Claims Payment Summary

This section is a summary of the claims payment activities as of the date indicated on the Remittance Statement and year-to-date (YTD) claims payment activities.

CLAIMS PAID OR DENIED	The total number of finalized claims which have been determined to be denied or paid by the Medicaid Program, as of the date indicated on the Remittance Statement and YTD summation of claim activity.
AMOUNT PAID	The total amount of claims that paid as of the date on the Remittance Statement and the YTD summation of payment activity.
WITHHELD	The dollar amount that has been recouped by Medicaid as of the date on the Remittance Statement (and YTD summation of recouped monies)
NET PAY AMOUNT	The dollar amount that appears on the check.
CREDIT AMOUNT	The dollar amount of a refund that a provider has sent in to EDS to adjust the 1099 amount (this amount does not affect claims payment, it only adjusts the 1099 amount).
NET 1099 AMOUNT	The total amount of money that the provider has received from the Medicaid Program as of the date on the Remittance Statement and the YTD total monies received taking into consideration recoupments and refunds.

G. Section VI - Description of Explanation Codes Listed Above

Each EOB code that appeared on the dated Remittance Statement will have a corresponding written explanation pertaining to payment, denial, suspension and return for a particular claim (Appendix IX P.5).

X. GENERAL INFORMATION - EDS

A. Correspondence Forms Instructions

Type of Information Requested	Time Frame for Inquiry	Mailing Address
Inquiry	6 weeks after billing	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Communications Unit
Adjustment	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Adjustments Unit
Refund	Immediately	EDS P.O. Box 2009 Frankfort, KY 40602 ATTN: Financial Services

Type of Information Requested	Necessary Information
Inquiry	1. Completed Inquiry Form 2. Remittance Advice or Medicare EOMB, when applicable. 3. Other supportive documentation, when needed, such as a photocopy of the Medicaid claim when a claim has not appeared on a Remittance Advice within a reasonable amount of time.

Type of Information Requested	Necessary Information
Adjustment	1. Completed Adjustment Form 2. Corrected Claim 3. Photocopy of the applicable portion of the Remittance Advice in question
Refund	1. Refund Check 2. Cash Refund Documentation Form 3. Photocopy of the applicable portion of the Remittance Advice in question 4. Reason for refund

B. Telephoned Inquiry Information

What is Needed?

-Provider number
-Patient's Medicaid ID number
-Date of service
-Billed amount
-Your name and telephone number

When to Call?

-When claim is not showing on paid, pending or denied sections of the Remittance Advice within 6 weeks
-When the status of claims is needed and they do not exceed five in number

Where to Call?

-Toll-free number 1-800-756-7557 (within Kentucky)
-Local (502) 227-2525

C. Filing Limitations

New Claims	-	12 months from date of service
Medicare and Medicaid Crossover Claims	-	12 months from date of service

NOTE: If the claim is a Medicare crossover claim and is received by EDS more than 12 months from date of service, but less than 6 months from the Medicare adjudication date, EDS considers the claim to be within the filing limitations and will proceed with claims processing.

Third-Party Liability Claims	-	12 months from date of service

NOTE: If the other insurance company has not responded within 120 days of the date a claim is submitted to the insurance company, submit the claim to EDS indicating "NO RESPONSE" from the other insurance company.

Adjustments	-	12 months from date the paid claim appeared on the Remittance Advice

D. Provider Inquiry Form

The Provider Inquiry form should be used for inquiries to EDS regarding paid or denied claims, billing concerns, and claim status. (If requesting more than one claim status, a Provider Inquiry form should be completed for each status request.) The Provider Inquiry Form should be completed in its entirety and mailed to the following address:

EDS
P.O. Box 2009
Frankfort, KY 40602

Supplies of the Provider Inquiry form may be obtained by writing to the above address or contacting EDS Provider Relations Unit at 1-(800)-756-7557 or 1-(502)-227-2525.

Please remit both copies of the Provider Inquiry form to EDS. Any additional documentation that would help clarify your inquiry should be attached. EDS will enter their response on the form and the yellow copy will be returned to the provider.

It is not necessary to complete a Provider Inquiry form when resubmitting a denied claim.

Provider Inquiry forms may not be used in lieu of the Medicaid [KMAP] claim forms, Adjustment forms, or any other document required by the Medicaid Program.

In certain cases it may be necessary to return the inquiry form to the provider for additional information if the inquiry is illegible or unclear.

Instructions for completing the Provider Inquiry form are found on the next page.

Following are field by field instructions for completing the Provider Inquiry form:

Field Number	Instructions
1	Enter your 8-digit Kentucky Medicaid Provider Number.
2	Enter your Provider Name and Address.
3	Enter the Medicaid recipient's name as it appears on the Medical Assistance I.D. Card.
4	Enter the recipient's 10 digit Medicaid ID number.
5	Enter the billed amount of the claim on which you are inquiring.
6	Enter the claim service date(s).
7	If you are inquiring in regard to an in-process, paid, or denied claim, enter the date of the Remittance Advice listing the claim.
8	If you are inquiring in regard to an in-process, paid, or denied claim, enter the 13 digit internal control number listed on the Remittance Advice for that particular claim.
9	Enter your specific inquiry.
10	Enter your signature and date of the inquiry.

E. Adjustment Request Form

The Adjustment Request form is to be used when requesting a change on a previously paid claim. This does not include denied claims or claims returned to the provider for requested additional information or documentation.

For prompt action and response to the adjustment requests, please complete all items. COPIES OF THE CLAIM AND THE APPROPRIATE PAGE OF THE REMITTANCE ADVICE MUST BE ATTACHED TO THE ADJUSTMENT REQUEST FORM. If items are not completed, the form may be returned.

Field Number	Description
1	Enter the 13-digit claim number for the particular claim in question.
2	Enter the recipient's name as it appears on the Remittance Advice (last name first).
3	Enter the complete recipient identification number as it appears on the Remittance Advice. The complete Medicaid number contains 10 digits.
4	Enter the provider's name, address and complete provider number.
5	Enter the "From Date of Service" for the claim in question.
6	Enter the "To Date of Service" for the claim in question.
7	Enter the total charges submitted on the original claim.